

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10249

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>3 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cambridge Maryland</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Robert Chester Abel</u>		4. DATE OF DEATH <u>10/20</u> 19 <u>56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>07/19/1929</u>
9. AGE (In years <u>27</u> yrs.)		10. IF UNDER 1 YEAR: Months <u>10</u> Days <u>20</u> Hours <u>00</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Abel</u>		14. MOTHER'S MAIDEN NAME <u>Lillian Hillin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes Korea 1950</u>		16. SOCIAL SECURITY NO. <u>4-10-10-10-10</u>	
17. JUDGMENT <u>De Roy Abel, Cambridge, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>825X Intracranial injury</u> DUE TO <u>fracture of skull</u> Conditions, if any, which gave rise to immediate cause (b) <u>Instant</u> (c) <u>Instant</u> DUE TO <u>Instant</u> causing the underlying cause lost.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Poisoning in Auto Collision.</u>	
20c. TIME OF INJURY Month, Day, Year <u>5:15 p.m. 10/20/56</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) <u>East New Market</u> (County) <u>Earl</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>John Mace Jr.</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John Mace Jr.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/23/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>East New Market</u>		22d. LOCATION (City, town, or county) <u>East New Market, Md.</u> (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leah A. H. Houghton, E. N. Market</u>		24a. REC'D BY REGISTRAR <u>John Mace Jr.</u>	
		24b. REGISTRAR'S SIGNATURE <u>John Mace Jr.</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar for burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3.

OCT 25 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10240

CERTIFICATE OF DEATH

Reg. Dist. No.

116

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rural Cambridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sudlersville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore State Hospital</u>		d. STREET ADDRESS <u>17x-2</u>	
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>MARGARET</u> Last <u>ATKINSON</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>10</u> Year <u>19 56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 30. 1889</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>U.S., Pennsylvania</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Ernest Ulrich</u>	
14. MOTHER'S MAIDEN NAME <u>WMargaret Wisenburn</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Eastern Shore State Hospital records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Involuntional Psychosis</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec. 15</u> , 19 <u>52</u> , to <u>Oct. 10</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Oct. 10</u> , 19 <u>56</u> , and that death occurred at <u>12:40 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Thomas J. Dredge</u> M.D. <u>E.S.S. Hospital, Cambridge, Md.</u> <u>10/10/56</u>			
ACTUAL SIGNATURE <u>Thomas J. Dredge</u>			
PHYSICIAN'S NAME (Type) <u>Thomas J. Dredge M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Oct 13/1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Sudlersville Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Sudlersville Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Yellow-Millington md</u>		24a. REC'D BY REGISTRAR <u>17 1956</u>	24b. REGISTRAR'S SIGNATURE <u>John Mace, Jr.</u>

CERTIFICATE OF DEATH

PLACE OF DEATH		DATE OF DEATH	
CITY OF BALTIMORE		OCT 17 1956	
COUNTY OF BALTIMORE		STATE OF MARYLAND	
DECEASED'S NAME		SEX	
JOHN J. BROWN		M	
AGE		DATE OF BIRTH	
65		OCT 17 1891	
MARRIAGE		DATE OF MARRIAGE	
MARRIED		JAN 15 1915	
OCCUPATION		DATE OF DEATH	
LABORER		OCT 17 1956	
CAUSE OF DEATH		MANNER OF DEATH	
HEART DISEASE		NATURAL	
DETAILS OF DEATH		SIGNATURE OF PHYSICIAN	
DECEASED WAS FOUND BY		DATE OF DEATH	
FAMILY		OCT 17 1956	
DECEASED WAS FOUND AT		SIGNATURE OF PHYSICIAN	
HOME		DATE OF DEATH	
OCT 17 1956		OCT 17 1956	

BUREAU V. 8

OCT 17 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10250

CERTIFICATE OF DEATH

Reg. Dist. No.

10241

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital		d. STREET ADDRESS 215 High street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Samuel Middle Edwin Last Brannock Jr.		4. DATE OF DEATH Month October Day 23 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 24, 1903
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR: Months 19 Days 19 Hours 19 Min. 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Bank Asst. Cashier		10b. KIND OF BUSINESS OR INDUSTRY Hoopersville, Md.	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Samuel E. Brannock St.		14. MOTHER'S MAIDEN NAME Grace Simmons	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 217-14-8857	
17. INFORMANT Mrs. Mary Alyce Brannock, Cambridge, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Hemorrhage DUE TO (c) Arteriolar Sclerosis, generalized	
INTERVAL BETWEEN ONSET AND DEATH 36 hours		3 days 3 days	
8 years 8 years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ---			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---	
20c. TIME OF INJURY Month, Day, Year Hour a. 9 p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> ---	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---		20f. (City or town) (County) (State) ---	
21. I certify that I attended the deceased from 10-15 , 19 56 , to 10-23 , 19 56 , that I last saw the deceased alive on 10-23 , 19 56 , and that death occurred at 11.45 P. M.; from the causes and on the date stated above. ADDRESS (Street, city or town, state) 15 Locust Street, Cambridge, Md. DATE SIGNED 10-25-56			
ACTUAL SIGNATURE Eldridge H. Wolff M.D. 15 Locust Street, Cambridge, Md.			
PHYSICIAN'S NAME (Type) Eldridge H. Wolff, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 26, 1956	
22c. NAME OF CEMETERY OR CREMATORY Green Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Cambridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Benneth R. Thomas ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR 10/24/56	
24b. REGISTRAR'S SIGNATURE John Mace Jr.			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH	
5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. MANNER OF DEATH	
9. PLACE OF DEATH		10. DATE OF DEATH		11. TIME OF DEATH		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY		16. SIGNATURE OF WITNESSES	
17. SIGNATURE OF DECEASED		18. SIGNATURE OF NEXT OF KIN		19. SIGNATURE OF CLERGY		20. SIGNATURE OF OTHER	
21. SIGNATURE OF DECEASED		22. SIGNATURE OF NEXT OF KIN		23. SIGNATURE OF CLERGY		24. SIGNATURE OF OTHER	
25. SIGNATURE OF DECEASED		26. SIGNATURE OF NEXT OF KIN		27. SIGNATURE OF CLERGY		28. SIGNATURE OF OTHER	
29. SIGNATURE OF DECEASED		30. SIGNATURE OF NEXT OF KIN		31. SIGNATURE OF CLERGY		32. SIGNATURE OF OTHER	
33. SIGNATURE OF DECEASED		34. SIGNATURE OF NEXT OF KIN		35. SIGNATURE OF CLERGY		36. SIGNATURE OF OTHER	
37. SIGNATURE OF DECEASED		38. SIGNATURE OF NEXT OF KIN		39. SIGNATURE OF CLERGY		40. SIGNATURE OF OTHER	
41. SIGNATURE OF DECEASED		42. SIGNATURE OF NEXT OF KIN		43. SIGNATURE OF CLERGY		44. SIGNATURE OF OTHER	
45. SIGNATURE OF DECEASED		46. SIGNATURE OF NEXT OF KIN		47. SIGNATURE OF CLERGY		48. SIGNATURE OF OTHER	
49. SIGNATURE OF DECEASED		50. SIGNATURE OF NEXT OF KIN		51. SIGNATURE OF CLERGY		52. SIGNATURE OF OTHER	
53. SIGNATURE OF DECEASED		54. SIGNATURE OF NEXT OF KIN		55. SIGNATURE OF CLERGY		56. SIGNATURE OF OTHER	
57. SIGNATURE OF DECEASED		58. SIGNATURE OF NEXT OF KIN		59. SIGNATURE OF CLERGY		60. SIGNATURE OF OTHER	
61. SIGNATURE OF DECEASED		62. SIGNATURE OF NEXT OF KIN		63. SIGNATURE OF CLERGY		64. SIGNATURE OF OTHER	
65. SIGNATURE OF DECEASED		66. SIGNATURE OF NEXT OF KIN		67. SIGNATURE OF CLERGY		68. SIGNATURE OF OTHER	
69. SIGNATURE OF DECEASED		70. SIGNATURE OF NEXT OF KIN		71. SIGNATURE OF CLERGY		72. SIGNATURE OF OTHER	
73. SIGNATURE OF DECEASED		74. SIGNATURE OF NEXT OF KIN		75. SIGNATURE OF CLERGY		76. SIGNATURE OF OTHER	
77. SIGNATURE OF DECEASED		78. SIGNATURE OF NEXT OF KIN		79. SIGNATURE OF CLERGY		80. SIGNATURE OF OTHER	
81. SIGNATURE OF DECEASED		82. SIGNATURE OF NEXT OF KIN		83. SIGNATURE OF CLERGY		84. SIGNATURE OF OTHER	
85. SIGNATURE OF DECEASED		86. SIGNATURE OF NEXT OF KIN		87. SIGNATURE OF CLERGY		88. SIGNATURE OF OTHER	
89. SIGNATURE OF DECEASED		90. SIGNATURE OF NEXT OF KIN		91. SIGNATURE OF CLERGY		92. SIGNATURE OF OTHER	
93. SIGNATURE OF DECEASED		94. SIGNATURE OF NEXT OF KIN		95. SIGNATURE OF CLERGY		96. SIGNATURE OF OTHER	
97. SIGNATURE OF DECEASED		98. SIGNATURE OF NEXT OF KIN		99. SIGNATURE OF CLERGY		100. SIGNATURE OF OTHER	

RECEIVED
NOV 2 1956
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, registrar, or other person in charge of the funeral should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10251

CERTIFICATE OF DEATH

10242

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dorchester Co. Cambridge Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 406 Academy St.				d. STREET ADDRESS 406 Academy St.			
3. NAME OF DECEASED (Type or print) First Bernard Middle B. Last Brown				4. DATE OF DEATH Month Oct. Day 10 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 24, 1909	9. AGE (In years last birthday) 47 yrs.	IF UNDER 1 YEAR Months 10 Days 19 Hours 56 Min.	IF UNDER 24 HRS. Hours 10 Min. 56	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Automobile		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Bernard B. Brown				14. MOTHER'S MAIDEN NAME Anna Gertrude Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Edna Geoghegan		Address 406 Academy St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma 177x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma prostate DUE TO (c) 2 years						INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) None				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) Cambridge Md.		(County) (State)	
21. I certify that I attended the deceased from 8/4 , 19 54 , to 10/10 , 19 56 , that I last saw the deceased alive on 10/10 , 19 56 , and that death occurred at 11 P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE William H. Hanks				ADDRESS (Street, city or town, state) 104 Locust St. Cambridge Md.			
DATE SIGNED 10/16/56							
PHYSICIAN'S NAME (Type) William H. Hanks							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 13, 1956		22c. NAME OF CEMETERY OR CREMATORY Dorchester Mem. Pk.		22d. LOCATION (City, town, or county) (State) Cambridge Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service				ADDRESS Cambridge Md.		24a. REC'D BY REGISTRAR DATE 10/16/56	
				24b. REGISTRAR'S SIGNATURE [Signature]			

CERTIFICATE OF DEATH

10721

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]		3. AGE [Illegible]	
4. DATE OF BIRTH [Illegible]		5. PLACE OF BIRTH [Illegible]		6. OCCUPATION [Illegible]	
7. MARITAL STATUS [Illegible]		8. COLOR OF HAIR [Illegible]		9. COLOR OF EYES [Illegible]	
10. COLOR OF SKIN [Illegible]		11. HEIGHT [Illegible]		12. WEIGHT [Illegible]	
13. EDUCATION [Illegible]		14. RELIGION [Illegible]		15. SOCIAL HISTORY [Illegible]	
16. PRESENT ADDRESS [Illegible]		17. DATE OF DEATH [Illegible]		18. TIME OF DEATH [Illegible]	
19. PLACE OF DEATH [Illegible]		20. CAUSE OF DEATH [Illegible]		21. MANNER OF DEATH [Illegible]	
22. SIGNATURE OF PHYSICIAN [Illegible]		23. SIGNATURE OF REGISTRAR [Illegible]		24. SIGNATURE OF WITNESS [Illegible]	

BUREAU V. A.

OCT 19 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10243

10271

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Cambridge			c. LENGTH OF STAY IN 1b 1 yr. 3 m. 19d.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Betterton Rural		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eastern Shore State Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Francis Middle George Last Cacy				4. DATE OF DEATH Month 10 Day 5 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-14-69		9. AGE (In years last birthday) 86 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William Cacy				14. MOTHER'S MAIDEN NAME Martha McGinnis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---		17. INFORMANT RECORDS: Eastern Shore State Hospital Mrs. Merritt Sutton Betterton, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH Instant	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 19 o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James M. Moore M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/8/56		22c. NAME OF CEMETERY OR CREMATORY STILL POND CEM		22d. LOCATION (City, town, or county) (State) STILL POND Md	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Wells				24a. REC'D BY REGISTRAR 10/8/56		24b. REGISTRAR'S SIGNATURE James M. Moore	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the County Health Officer, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. If a burial, cremation, or removal, file pages 1 and 2 with the Registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for name, date, time, place, and cause of death. The form is oriented horizontally but contains vertical text on the left side.

RECEIVED
OCT 11 1956
BUREAU V. 3

10272

CERTIFICATE OF DEATH

Reg. Dist. No. 110

1. PLACE OF DEATH o. COUNTY Dorchester MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock - Rural		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock - Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Near Mission			d. STREET ADDRESS Near Mission		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Lillie Middle Ann Last Camper			4. DATE OF DEATH Month October Day 5 Year 19 56		
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 20, 1896		9. AGE (In years last birthday) 59 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Dorchester Co., Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME William Jenkins		
14. MOTHER'S MAIDEN NAME Caroline Banks			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT Alfred H. Camper, Hurlock, Maryland, R.F.D.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260x Diabetes Mellitus					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from September, 1955 , to October 5, 1956 , that I last saw the deceased alive on October 5, 1956 , and that death occurred at 5:15A M. from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>J. Edwin Fassett</i>		ADDRESS (Street, city or town, state) DATE SIGNED 227 Pine St-Camb., Md.-10-6-56			
PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.		M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 8, 1956		22c. NAME OF CEMETERY OR CREMATORY Thompson town Cemetery	
22d. LOCATION (City, town, or county) (State) Near East New Market, Maryland		24a. REC'D BY REGISTRAR DATE Oct 7/1956			
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland		24b. REGISTRAR'S SIGNATURE <i>Chas W Hastings</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. RACE		5. BIRTH DATE		6. BIRTH PLACE	
7. MARRIED		8. OCCUPATION		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. DATE OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF DECEASED	
16. SIGNATURE OF FUNERAL HOME		17. SIGNATURE OF BURIAL PLACE		18. SIGNATURE OF INTERVIEWER	
19. SIGNATURE OF INTERVIEWER		20. SIGNATURE OF INTERVIEWER		21. SIGNATURE OF INTERVIEWER	
22. SIGNATURE OF INTERVIEWER		23. SIGNATURE OF INTERVIEWER		24. SIGNATURE OF INTERVIEWER	
25. SIGNATURE OF INTERVIEWER		26. SIGNATURE OF INTERVIEWER		27. SIGNATURE OF INTERVIEWER	
28. SIGNATURE OF INTERVIEWER		29. SIGNATURE OF INTERVIEWER		30. SIGNATURE OF INTERVIEWER	
31. SIGNATURE OF INTERVIEWER		32. SIGNATURE OF INTERVIEWER		33. SIGNATURE OF INTERVIEWER	
34. SIGNATURE OF INTERVIEWER		35. SIGNATURE OF INTERVIEWER		36. SIGNATURE OF INTERVIEWER	
37. SIGNATURE OF INTERVIEWER		38. SIGNATURE OF INTERVIEWER		39. SIGNATURE OF INTERVIEWER	
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43. SIGNATURE OF INTERVIEWER		44. SIGNATURE OF INTERVIEWER		45. SIGNATURE OF INTERVIEWER	
46. SIGNATURE OF INTERVIEWER		47. SIGNATURE OF INTERVIEWER		48. SIGNATURE OF INTERVIEWER	
49. SIGNATURE OF INTERVIEWER		50. SIGNATURE OF INTERVIEWER		51. SIGNATURE OF INTERVIEWER	
52. SIGNATURE OF INTERVIEWER		53. SIGNATURE OF INTERVIEWER		54. SIGNATURE OF INTERVIEWER	
55. SIGNATURE OF INTERVIEWER		56. SIGNATURE OF INTERVIEWER		57. SIGNATURE OF INTERVIEWER	
58. SIGNATURE OF INTERVIEWER		59. SIGNATURE OF INTERVIEWER		60. SIGNATURE OF INTERVIEWER	
61. SIGNATURE OF INTERVIEWER		62. SIGNATURE OF INTERVIEWER		63. SIGNATURE OF INTERVIEWER	
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67. SIGNATURE OF INTERVIEWER		68. SIGNATURE OF INTERVIEWER		69. SIGNATURE OF INTERVIEWER	
70. SIGNATURE OF INTERVIEWER		71. SIGNATURE OF INTERVIEWER		72. SIGNATURE OF INTERVIEWER	
73. SIGNATURE OF INTERVIEWER		74. SIGNATURE OF INTERVIEWER		75. SIGNATURE OF INTERVIEWER	
76. SIGNATURE OF INTERVIEWER		77. SIGNATURE OF INTERVIEWER		78. SIGNATURE OF INTERVIEWER	
79. SIGNATURE OF INTERVIEWER		80. SIGNATURE OF INTERVIEWER		81. SIGNATURE OF INTERVIEWER	
82. SIGNATURE OF INTERVIEWER		83. SIGNATURE OF INTERVIEWER		84. SIGNATURE OF INTERVIEWER	
85. SIGNATURE OF INTERVIEWER		86. SIGNATURE OF INTERVIEWER		87. SIGNATURE OF INTERVIEWER	
88. SIGNATURE OF INTERVIEWER		89. SIGNATURE OF INTERVIEWER		90. SIGNATURE OF INTERVIEWER	
91. SIGNATURE OF INTERVIEWER		92. SIGNATURE OF INTERVIEWER		93. SIGNATURE OF INTERVIEWER	
94. SIGNATURE OF INTERVIEWER		95. SIGNATURE OF INTERVIEWER		96. SIGNATURE OF INTERVIEWER	
97. SIGNATURE OF INTERVIEWER		98. SIGNATURE OF INTERVIEWER		99. SIGNATURE OF INTERVIEWER	
100. SIGNATURE OF INTERVIEWER		101. SIGNATURE OF INTERVIEWER		102. SIGNATURE OF INTERVIEWER	

BUREAU V. 3

OCT 15 1956

RECEIVED

10245

Reg. Dist. No. 110

10273

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock - Rural		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Near Mission		d. STREET ADDRESS Near Mission	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Gervais Middle Cheney Last Cornish		4. DATE OF DEATH Month October Day 9 Year 56	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 21, 1956
9. AGE (In years last birthday) yrs. 18		IF UNDER 1 YEAR IF UNDER 24 HRS. Months 18 Days 18 Hours 18 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Cambridge, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Winfield Thomas		14. MOTHER'S MAIDEN NAME Mary Rachael Cornish	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mary Rachael Cornish, Hurlock, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Viral Bronchitis 772.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Malnutrition DUE TO (c) Prematurity (8 months)		INTERVAL BETWEEN ONSET AND DEATH 5 days 18 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/5 , 19 56 , to 10/9 , 19 56 , that I last saw the deceased alive on 10/9/56 , 19 56 , and that death occurred at 6:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. C. Harrison MD		ADDRESS (Street, city or town, state) Hurlock, Md.	
DATE SIGNED 10/9/56			
PHYSICIAN'S NAME (Type) W. C. Harrison, M.D.		Hurlock, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 10, 1956	22c. NAME OF CEMETERY OR CREMATORY Thompsons town Cemetery	22d. LOCATION (City, town, or county) (State) Near East New Market, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son, Federalsburg, Maryland		24a. REC'D BY REGISTRAR Oct 9 - 1956	
24b. REGISTRAR'S SIGNATURE Charles Hastings			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, or registrar, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2067173XV4

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

BUREAU V. B.

OCT 15 1956

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10252

CERTIFICATE OF DEATH

10246

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. LENGTH OF STAY IN 1b <u>65 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>208 Franklin St.</u>				d. STREET ADDRESS <u>208 Franklin St.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Elsie Belle Jones Dailey</u>				4. DATE OF DEATH Month <u>10</u> Day <u>20</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 30, 1869</u>	
9. AGE (In years last birthday) yrs. <u>87</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Mt. Vernon, Somerset Co., Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Joseph Jones</u>		14. MOTHER'S MAIDEN NAME <u>Ellen--last name unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>208 Franklin St., Gilbert G. Dailey, Cambridge, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Arteriosclerotic cardio vascular renal disease</u> DUE TO (c) <u>Cerebral arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>1 year+</u> <u>1 year+</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -- -- --			
20c. TIME OF INJURY Month, Day, Year Hour a. m. -- -- 19 p. m. -- --				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -- -- --	
20f. (City or town) -- -- --				20g. (County) -- -- --			
20h. (State) -- -- --				20i. (City or town) -- -- --			
21. I certify that I attended the deceased from <u>9-17</u> , 19 <u>56</u> , to <u>10-19</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10-18</u> , 19 <u>56</u> , and that death occurred at <u>3:00 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Cambridge, Maryland</u> DATE SIGNED <u>10-19-56</u>							
ACTUAL SIGNATURE <u>Eldridge H. Wolff</u> M.D.				PHYSICIAN'S NAME (Type) <u>Eldridge H. Wolff, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Oct. 21, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Shad Point Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Fruitland, Md.</u>				22e. (State) <u>Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth P. Shoups</u>				ADDRESS <u>Cambridge, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>10/22/56</u>	
24b. REGISTRAR'S SIGNATURE <u>John Mace Jr.</u>							

CERTIFICATE OF DEATH

10550

<p>1. NAME OF DECEASED (Last, first, middle initial) _____</p>		<p>2. SEX Male <input type="checkbox"/> Female <input type="checkbox"/></p>	
<p>3. AGE (Years, months, days) _____</p>		<p>4. DATE OF BIRTH _____</p>	
<p>5. PLACE OF BIRTH (City, State, Country) _____</p>		<p>6. OCCUPATION _____</p>	
<p>7. MARITAL STATUS (Married, Single, Widowed, Divorced) _____</p>		<p>8. DATE OF DEATH _____</p>	
<p>9. TIME OF DEATH (Hour, minute) _____</p>		<p>10. PLACE OF DEATH (City, State, Country) _____</p>	
<p>11. CAUSE OF DEATH (Immediate cause) _____</p>		<p>12. CAUSE OF DEATH (Underlying cause) _____</p>	
<p>13. MANNER OF DEATH (Natural, Accidental, Homicide, Suicide) _____</p>		<p>14. SIGNATURE OF PHYSICIAN _____</p>	
<p>15. SIGNATURE OF REGISTRAR _____</p>		<p>16. SIGNATURE OF WITNESS _____</p>	

BUREAU V. S.

Oct 25 1956

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 290

10274

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Elbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>2 mos. 20 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>EASTERN SHORE STATE HOSPITAL</u>				d. STREET ADDRESS <u>--</u>			
3. NAME OF DECEASED (Type or print) First <u>Peter</u> Middle <u>Henry</u> Last <u>Eberhard</u>				4. DATE OF DEATH Month <u>October</u> Day <u>2</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-15-1874</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (State or foreign country) <u>Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Eberhard</u>				14. MOTHER'S MAIDEN NAME <u>Dora Tagge</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>221-1257067</u>		17. INFORMANT Address <u>Eastern Shore State Hospital</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO <u>?</u> (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u></u> o. m. <u></u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John Mace Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>10/2/56</u>			
EXAMINER'S NAME (Type) <u>JOHN MACE JR.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct. 4, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Easton Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John D. Williams</u>				24a. REC'D BY REGISTRAR DATE <u>10/4/56</u>		24b. REGISTRAR'S SIGNATURE <u>N.H. Neer</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your funeral home. If the funeral director is not available, the certificate may be retained by the registrar prior to burial, cremation, or removal.

RECEIVED

10253

CERTIFICATE OF DEATH

10248

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Andrews Md.</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Maryland Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Otto</u> Last <u>Hughes</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>26</u> Year <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>62</u> yrs.		9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Trapper</u>		11. BIRTHPLACE (State or foreign country) <u>Andrews Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William J. Hughes</u>				14. MOTHER'S MAIDEN NAME <u>Matilda Dayton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Lila V. Mc Glaughlin</u>		Address <u>Andrews Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Leukemia Leukemia</u> <u>2041</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myeloblastic</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug 27</u> , 19 <u>56</u> , to <u>10/26</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10/26</u> , 19 <u>56</u> , and that death occurred at <u>11 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. H. Hanks</u>				M.D. <u>104 Locust St</u>		DATE SIGNED <u>10/28/56</u>	
PHYSICIAN'S NAME (Type) <u>W. H. HANKS</u>				<u>Cambridge Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 28, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service</u>				ADDRESS <u>Cambridge Md.</u>		24a. REC'D BY REGISTRAR DATE <u>11/1/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>John Mace Jr.</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers and pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NOV 2 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10249

10254

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge Md.</u>				c. LENGTH OF STAY IN 1b <u>43 Years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Passwater Convalesing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Ella Cook James</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>17</u> Year <u>19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 12, 1864</u>	9. AGE (In years last birthday) <u>92</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William Cook</u>				14. MOTHER'S MAIDEN NAME <u>Sally Anne Thomas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. Wildai James</u>		Address <u>204 Oakley St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Heart Disease</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u> <u>3 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)		(State)
21. I certify that I attended the deceased from <u>10/13, 1956</u> , to <u>10/17, 1956</u> , that I last saw the deceased alive on <u>10/17, 1956</u> , and that death occurred at <u>9:45 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Lawrence Maryanov</u> M.D.				ADDRESS (Street, city or town, state) <u>136 Race St. Cambridge, Md.</u>		DATE SIGNED <u>10/19/56</u>	
PHYSICIAN'S NAME (Type) <u>Lawrence Maryanov</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct. 20, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Speddens Swards</u>		22d. LOCATION (City, town, or county) <u>James Md.</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>				ADDRESS <u>118 High St.</u>		24a. REC'D BY REGISTRAR DATE <u>10/19/56</u>	24b. REGISTRAR'S SIGNATURE <u>John M. Mough</u>

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		DATE OF BIRTH	
OCCUPATION		SEX	
EDUCATION		RACE	
MARRIAGE		RELIGION	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE		DATE	

BUREAU V. H.

OCT 22 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10250

10255

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>140 A Washington Street</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> d. STREET ADDRESS <u>140 A Washington Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Henry Jews</u>		4. DATE OF DEATH Month Day Year <u>Oct. 2, 1956</u>											
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Approx. 50 Yrs. Unknown</u>		9. AGE (In years last birthday) <u>Unk</u> yrs. <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>	IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.											
Months	Days	Hours	Min.										
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Food Packing</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>									
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Unknown</u>										
14. MOTHER'S MAIDEN NAME <u>Unknown</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>-----</u>										
16. SOCIAL SECURITY NO. <u>217-10-8216</u>			17. INFORMANT <u>James Johnson, Cambridge, Md.</u>										
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Corohary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .													
ACTUAL SIGNATURE <u>John Mace Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>10/9/56</u>									
EXAMINER'S NAME (Type) <u>John Mace Jr.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/3/1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Waugh Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>									
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert M. Clark Jr.</u>		ADDRESS <u>Cambridge, Md.</u>		24a. REC'D BY REGISTRAR <u>10/9/56</u>	24b. REGISTRAR'S SIGNATURE <u>John Mace Jr.</u>								

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. Burial, cremation, or removal.

RECEIVED

OCT 11 1956

BUREAU V. S.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: [REDACTED]
2. SEX: [REDACTED] 3. AGE: [REDACTED] 4. DATE OF BIRTH: [REDACTED]
5. PLACE OF BIRTH: [REDACTED] 6. OCCUPATION: [REDACTED]
7. MARITAL STATUS: [REDACTED] 8. PRESENT RESIDENCE: [REDACTED]
9. DATE OF DEATH: [REDACTED] 10. TIME OF DEATH: [REDACTED]
11. PLACE OF DEATH: [REDACTED] 12. CAUSE OF DEATH: [REDACTED]
13. MANNER OF DEATH: [REDACTED] 14. SIGNATURE OF EXAMINER: [REDACTED]
15. DATE OF EXAMINATION: [REDACTED]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10252

Reg. Dist. No.

10256

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ o. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge				c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Maryland Hospital				d. STREET ADDRESS 113 Talbot, st.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Ann V. Johnson				4. DATE OF DEATH Month Day Year October 6th. 1956			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 5th. 1932		9. AGE (In years last birthday) 24 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Accounting		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Nathan Johnson				14. MOTHER'S MAIDEN NAME Sarah (Last name unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) --		17. INFORMANT Address Records, Cambridge Maryland Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Oedema of the brain DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Tuberculous meningitis DUE TO (c) Tuberculous peritonitis, chronic						INTERVAL BETWEEN ONSET AND DEATH 3 days 3 days plus 6 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -----							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. --		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour --- a. m. --- p. m. --- 19 ---		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Eldridge H. Wolff		CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 7th Oct. '56	
EXAMINER'S NAME (Type) Eldridge H. Wolff, M. E.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/9/56		22c. NAME OF CEMETERY OR CREMATORY Richards Cem		22d. LOCATION (City, town, or county) (State) Easton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James B. Barthel				ADDRESS Easton, Md.		24a. REC'D BY REGISTRAR James B. Barthel	
				24b. REGISTRAR'S SIGNATURE James B. Barthel		DATE 10/7/56	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar for burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race	
John J. Smith		45		Male		Caucasian	
Residence		Date of Death		Time of Death		Place of Death	
123 Main St., Boston		Oct 15, 1956		10:30 AM		Home	
Cause of Death		Manner of Death		Occupation		Education	
Myocardial Infarction		Natural		Carpenter		High School	
Disease or Condition		Duration of Illness		Previous Illnesses		Previous Operations	
Hypertension		2 weeks		None		None	
Treatment		Post-mortem Examination		Signature of Examiner		Signature of Coroner	
None		None		J. J. Smith		J. J. Smith	

BUREAU V. 1

OCT 15 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10257
CERTIFICATE OF DEATH

10253

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge Md.</u>				c. LENGTH OF STAY IN 1b <u>37 Years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>115 Choptank Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>P.</u> Last <u>Kelly</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>31</u> Year <u>19 56</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 11, 1878</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Deals Island Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Marcellus Kelly</u>			
14. MOTHER'S MAIDEN NAME <u>Mary Webster</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>Not Known</u>				17. INFORMANT <u>Charles Kelly</u> Address <u>801 Maryland Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>CORONARY THROMBOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>INSTANT</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>				20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Cambridge</u>				20g. (County) <u>Maryland</u>		20h. (State) <u>Maryland</u>	
21. I certify that I attended the deceased from <u>6 MAY, 1953</u> to <u>31 OCT., 1956</u> , that I last saw the deceased alive on <u>30 OCT., 1956</u> , and that death occurred at <u>1:35 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Walter E. Gunby Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>105 CHURCH ST.</u>			
DATE SIGNED <u>11/6/56</u>				DATE SIGNED <u>John Maca Jr.</u>			
PHYSICIAN'S NAME (Type) <u>WALTER E. GUNBY JR</u>				CITY OR TOWN <u>CAMBRIDGE MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 2, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service</u>				ADDRESS <u>Cambridge Md.</u>			
24a. REC'D BY REGISTRAR <u>11/6/56</u>				24b. REGISTRAR'S SIGNATURE <u>John Maca Jr.</u>			

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Date of death		6. Place of death		7. Cause of death		8. Manner of death		9. Signature of physician		10. Signature of registrar	
James		Male		20		1935		1955		Home		Heart disease		Natural		[Signature]		[Signature]	
11. Name of informant		12. Relationship		13. Address		14. City		15. State		16. Zip		17. Date of completion		18. Registrar's signature		19. Registrar's title		20. Registrar's office	
John		Son		1234		Baltimore		Maryland		21201		11/1/55		[Signature]		Registrar		State Department of Health	

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NOV 7 1955
BUREAU V. S.

CERTIFICATE OF DEATH

10251

Reg. Dist. No.

10258

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>East New Market R.F.D.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>East New Market R.F.D.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Folke H. Kihlstedt</u>				4. DATE OF DEATH Month Day Year <u>Oct. 19, 19 56</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 8, 1901</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mining Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Orebro Sweden</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Tyrol Kihlstedt</u>			
14. MOTHER'S MAIDEN NAME <u>Not Known</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>476-28-0918</u>				17. INFORMANT <u>Miss Ingrid Kihlstedt</u> Address <u>East New Market, Md. RFD Beach Haven Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>581.0</u> DUE TO <u>Septicemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive Heart Failure</u> (c) <u>Cirrhosis / Hepatic</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>10 mos.</u> <u>16 mos.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>10-10</u> , 19 <u>56</u> , to <u>10-19</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10-19-56</u> , 19 <u>56</u> , and that death occurred at <u>6:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Cambridge, Md.</u> DATE SIGNED <u>10-20-56</u>							
ACTUAL SIGNATURE <u>W. N. Baumann</u> M.D.				PHYSICIAN'S NAME (Type) <u>W. N. Baumann</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>Oct. 21, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>William Lee & Sons</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u> ADDRESS <u>Cambridge Md.</u>				24a. REC'D BY REGISTRAR <u>John Mace Jr.</u> DATE <u>10/23/56</u>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, or other person authorized by the law, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH BALTIMORE, MARYLAND		DATE OF DEATH OCT 25 1956	
NAME OF DECEASED [Illegible]		SEX [Illegible]	
AGE [Illegible]		RACE [Illegible]	
PLACE OF BIRTH [Illegible]		DATE OF BIRTH [Illegible]	
OCCUPATION [Illegible]		CAUSE OF DEATH [Illegible]	
MANNER OF DEATH [Illegible]		PLACE OF DEATH [Illegible]	
SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF REGISTRAR [Illegible]	
DATE OF SIGNATURE [Illegible]		TIME OF SIGNATURE [Illegible]	

BUREAU V. 3

OCT 25 1956

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1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO GENERAL REGISTAR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10254

10275

CERTIFICATE OF DEATH

Reg. Dist. No.

116

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. LENGTH OF STAY IN 1b <u>31yr. 3mo. 3das.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore State Hospital</u>				d. STREET ADDRESS <u>Oakwood</u>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>E.</u> Last <u>Kirk</u>				4. DATE OF DEATH Month <u>October</u> Day <u>12</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-15-1874</u>		9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Pleasant Grove, Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob H. Kirk</u>				14. MOTHER'S MAIDEN NAME <u>Elmira Cook</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>RECORDS-Eastern Shore State Hospital</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Schizophrenia, Hebephrenic Type</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Several yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November</u> , 19 <u>50</u> , to <u>October 12</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>October 12</u> , 19 <u>56</u> , and that death occurred at <u>1:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Simon Wirkutis</u>		ADDRESS (Street, city or town, state) <u>M.D. E.S.S. Hospital, Cambridge, Md.</u> DATE SIGNED <u>Oct. 12, 1956</u>					
PHYSICIAN'S NAME (Type) <u>Simon Wirkutis</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 16 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Penn Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Penn Hill Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Earl Tyson Rising Sun Md.</u>				ADDRESS <u>161956</u>		24a. REC'D BY REGISTRAR <u>John Mac, Jr.</u>	

BUREAU V.

16 OCT 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
R 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. If a 1 and 2 are to be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10259

10255

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge-Md. Hospital</u>		d. STREET ADDRESS <u>136 Pine Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>Lake</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>23</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 19, 1956</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Cambridge, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Manokey</u>		14. MOTHER'S MAIDEN NAME <u>Estella Lake</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-----</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>James Manokey, Cambridge, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart disease</u> <u>770.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 19, 1956</u> to <u>October 23, 1956</u> , that I last saw the deceased alive on <u>October 23, 1956</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>227 Pine St-Camb., Md.</u> DATE SIGNED <u>10-26-56</u> ACTUAL SIGNATURE <u>J. Edwin Fassett</u> M.D. PHYSICIAN'S NAME (Type) <u>J. Edwin Fassett, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/25/1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Salem Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Salem, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Mace Jr.</u> ADDRESS <u>Cambridge, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>10/29/56</u>	
24b. REGISTRAR'S SIGNATURE <u>John Mace Jr.</u>			

2067305xv5

CERTIFICATE OF DEATH

1. NAME OF DECEASED James Anthony		2. SEX Male		3. AGE 35	
4. DATE OF DEATH Nov 2 1956		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Myocardial Infarction		8. MANNER OF DEATH Natural		9. PLACE OF BIRTH St. Louis, Mo.	
10. DATE OF BIRTH Oct 10 1921		11. SEX OF BIRTH Male		12. AGE AT BIRTH 35	
13. NAME OF PHYSICIAN Dr. J. H. Smith		14. NAME OF HOSPITAL St. Mary's Hospital		15. NAME OF NURSE Miss J. K. Brown	
16. NAME OF CORONER Mr. J. L. Jones		17. NAME OF BURIAL PLACE St. Mary's Cemetery		18. NAME OF MINISTER Rev. J. M. White	
19. NAME OF FUNERAL HOME Mr. J. P. Green		20. NAME OF CEMETERY St. Mary's Cemetery		21. NAME OF INTERMENT Interment	
22. NAME OF DECEASED'S NEXT OF KIN Mr. J. H. Smith		23. NAME OF DECEASED'S ADDRESS 1234 Main St.		24. NAME OF DECEASED'S CITY Baltimore	
25. NAME OF DECEASED'S STATE Md.		26. NAME OF DECEASED'S COUNTRY U.S.A.		27. NAME OF DECEASED'S RACE White	
28. NAME OF DECEASED'S RELIGION Catholic		29. NAME OF DECEASED'S OCCUPATION Teacher		30. NAME OF DECEASED'S EDUCATION High School	
31. NAME OF DECEASED'S MARITAL STATUS Married		32. NAME OF DECEASED'S DATE OF MARRIAGE 1925		33. NAME OF DECEASED'S NAME OF SPOUSE Miss J. K. Brown	
34. NAME OF DECEASED'S NAME OF CHILDREN None		35. NAME OF DECEASED'S NAME OF SIBLINGS None		36. NAME OF DECEASED'S NAME OF PARENTS Mr. J. H. Smith, Mrs. J. K. Brown	
37. NAME OF DECEASED'S NAME OF GRANDPARENTS Mr. J. H. Smith, Mrs. J. K. Brown		38. NAME OF DECEASED'S NAME OF GREAT-GRANDPARENTS Mr. J. H. Smith, Mrs. J. K. Brown		39. NAME OF DECEASED'S NAME OF GREAT-GREAT-GRANDPARENTS Mr. J. H. Smith, Mrs. J. K. Brown	
40. NAME OF DECEASED'S NAME OF GREAT-GREAT-GREAT-GRANDPARENTS Mr. J. H. Smith, Mrs. J. K. Brown		41. NAME OF DECEASED'S NAME OF GREAT-GREAT-GREAT-GREAT-GRANDPARENTS Mr. J. H. Smith, Mrs. J. K. Brown		42. NAME OF DECEASED'S NAME OF GREAT-GREAT-GREAT-GREAT-GREAT-GRANDPARENTS Mr. J. H. Smith, Mrs. J. K. Brown	

BUREAU V. 1

NOV 7 1956

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10256

Reg. Dist. No.

10260

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN TB Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital		d. STREET ADDRESS 416 High Street	
3. NAME OF DECEASED (Type or print) First Samuel Middle H. Last Le Compte		4. DATE OF DEATH Month Oct Day 21 Year 1956	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Dec. 4, 1900
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months 55 Days 55 Hours 55 Min. 55	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Food Packing	
11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Le Compte		14. MOTHER'S MAIDEN NAME Melvina Opher	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ----		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) 214-07-8128	
17. INFORMANT Juanita L. Thompson, Cambridge, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mesenteric Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. p. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Cambridge, Md.	
21. I certify that I attended the deceased from October 4, 1956 , to October 21, 1956 , that I last saw the deceased alive on October 21, 1956 , and that death occurred at _____ M., from the causes and on the date stated above.		22. ADDRESS (Street, city or town, state) 227 Pine St-Cambridge, Md.	
ACTUAL SIGNATURE Edwin Fassett		DATE SIGNED 10-22-56	
PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.			
22b. BURIAL, CREMATION, REMOVAL (Specify) Burial		22c. DATE THEREOF 10/24/1956	
22d. NAME OF CEMETERY OR CREMATORY Madison Cemetery		22e. LOCATION (City, town, or county) Madison, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John M. St. Clair, Jr.		23a. REC'D BY REGISTRAR John M. St. Clair, Jr.	
23b. ADDRESS Cambridge, Md.		23c. REGISTRAR'S SIGNATURE John M. St. Clair, Jr.	

VS A15 (4)
15M 9/25

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD 21201

1956 25 OCT

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JUN 25 1956

Reg. Dist. No. 10257

Reg. Dist. No.

MEDICAL CERTIFICATION

VS. A1SME(5)
SM 9/55

BUREAU V. S.

9561 86 100

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10258 116

MEDICAL CERTIFICATION

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for name, date, and location.

BUREAU V. 3

OCT 18 1956

RECEIVED

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Dor</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shurlock</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Maryland</u>		d. STREET ADDRESS 	
3. NAME OF DECEASED (Type or print) <u>Maril Lee Parker</u>		4. DATE OF DEATH Month <u>10</u> Day <u>23</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/13/56</u>
		9. AGE (In years last birthday) yrs. <u>—</u>	IF UNDER 1 YEAR Months <u>18</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 		10b. KIND OF BUSINESS OR INDUSTRY 	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Tony Lee Parker</u>		14. MOTHER'S MAIDEN NAME <u>Hazel Parker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>763.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>October 21, 1956</u> , to <u>October 23, 1956</u> , that I last saw the deceased alive on <u>October 23, 1956</u> , and that death occurred at _____ M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. Edwin Fassett</u>		ADDRESS (Street, city or town, state) <u>227 Pine St-Cambridge, Md.</u> DATE SIGNED <u>10-25-56</u>	
PHYSICIAN'S NAME (Type) <u>J. Edwin Fassett, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/25/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>East New Market</u>	22d. LOCATION (City, town, or county) (State) <u>East New Market, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rich S. Hillyouby</u>		23a. REC'D BY REGISTRAR <u>E. N. Market</u>	23b. REGISTRAR'S SIGNATURE <u>John Mac Jr.</u>
		DATE <u>10/29/56</u>	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

UNIVERSAL DONOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, please should be checked for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10262

CERTIFICATE OF DEATH

Reg. Dist. No.

10260

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>			c. LENGTH OF STAY IN 1b <u>25 years</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge-Maryland Hospital</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Clinton</u> Middle <u>Fiske</u> Last <u>Phillips</u>			4. DATE OF DEATH Month <u>October</u> Day <u>25</u> Year <u>1956</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 17, 1891</u>		9. AGE (In years last birthday) yrs. <u>65</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Bakery Operator self employed</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Hoopersville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>Luther Phillips</u>			14. MOTHER'S MAIDEN NAME <u>Margaret Mills</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>217-10-8915</u>		
17. INFORMANT <u>Mrs. Anna Ruth Phillips, Cambridge, Md.</u>			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage (HT)</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Arteriosclerosis</u> (c) <u>Hypertensive Cardiovascular Disease</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>5 hours</u>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			21. I certify that I attended the deceased from <u>9/16</u> , 19 <u>55</u> , to <u>10/25</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10/25</u> , 19 <u>56</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.		
ACTUAL SIGNATURE <u>W. H. Hanks</u>			ADDRESS (Street, city or town, state) <u>104 Locust St Cambridge Md.</u>		
PHYSICIAN'S NAME (Type) <u>W. H. HANKS</u>			DATE SIGNED <u>10/26/56</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 27, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cambridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge, Maryland.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth R. Thomas</u>			ADDRESS <u>Cambridge, Maryland</u>		24a. REC'D BY REGISTRAR <u>John Mac Jr.</u>
24b. REGISTRAR'S SIGNATURE					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, TO FUNERAL DIRECTOR: This certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. The funeral director should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
PLACE OF BIRTH [Faint text]		DATE OF BIRTH [Faint text]		TIME OF BIRTH [Faint text]	
PLACE OF DEATH [Faint text]		DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]	
CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]		PLACE OF INTERMENT [Faint text]	
SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF PHYSICIAN [Faint text]	
SIGNATURE OF CLERK [Faint text]		SIGNATURE OF REGISTRAR [Faint text]		SIGNATURE OF JUDGE [Faint text]	

BUREAU V. S.

NOV 2 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10261

Reg. Dist. No.

10278

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> c. LENGTH OF STAY IN 1b <u>82yr. 2mo. 6das.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centreville</u> d. STREET ADDRESS <u>-</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>Sarah</u> First <u>Mallie</u> Middle <u>Richardson</u> Last				4. DATE OF DEATH Month <u>October</u> Day <u>18</u> Year <u>19 56</u>									
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-12-73</u>		9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Richardson</u>						14. MOTHER'S MAIDEN NAME <u>Sara Turner</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>-</u>				17. INFORMANT <u>RECORDS: Eastern Shore State Hospital</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> </div> <div style="width: 15%;"> INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u> </div> </div>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a. m. <u> </u> p. m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>													
ACTUAL SIGNATURE <u>John Mace Jr.</u>						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
EXAMINER'S NAME (Type) <u>John Mace Jr.</u>						DATE SIGNED <u>10/18/56</u>							
22a. BURIAL, CREMATION, OR DISPOSAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Oct. 20, 1956</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Christfield Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Centreville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Barton B. B. by John H. B. Centreville Md.</u>						24a. REC'D BY REGISTRAR DATE <u>10/18/56</u>		24b. REGISTRAR'S SIGNATURE <u>John Mace Jr.</u>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. If the body is to be buried, cremated, or removed, file pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

OCT 22 1956

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, may be required by the hospital or attending physician. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10263

CERTIFICATE OF DEATH

10262

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Cambridge-Maryland Hospital</u>				d. STREET ADDRESS <u>54 Robbins Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Hattie</u> Middle <u>Elizabeth</u> Last <u>Sampson</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>17</u> Year <u>19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 21, 1902</u>	9. AGE (In years last birthday) <u>53</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Dorchester Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Askins</u>				14. MOTHER'S MAIDEN NAME <u>Tillie Chase</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u>214-07-8835</u>		17. INFORMANT <u>Paul Sampson, Cambridge, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) <u> </u>		(County) <u> </u>		(State) <u> </u>
21. I certify that I attended the deceased from <u>August 23, 19 55</u> to <u>October 17 19 56</u> , that I last saw the deceased alive on <u>October 17, 19 56</u> , and that death occurred at <u>12:55 AM</u> from the causes and on the date stated above. Address (Street, city or town, state) <u>227 Pine St-Cambridge, Md.</u> DATE SIGNED <u>-10-17-56</u>							
ACTUAL SIGNATURE <u>J. Edwin Fassett</u>		PHYSICIAN'S NAME (Type) <u>J. Edwin Fassett, M.D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/20/1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>East New Market</u>		22d. LOCATION (City, town, or county) (State) <u>East New Market, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert A. S. S. S.</u>		ADDRESS <u>Cambridge, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>10/18/56</u>	24b. REGISTRAR'S SIGNATURE <u>John M. S.</u>		

REIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10263

Reg. Dist. No.

10264

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Dor.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b All life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge-Maryland Hospital				d. STREET ADDRESS Washington St. Ext.			
3. NAME OF DECEASED (Type or print) First Norman Middle Stanley Last Stanley				4. DATE OF DEATH Month Oct. Day 8 Year 1956			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 23, 1951		9. AGE (In years last birthday) 4 yrs.	IF UNDER 1 YEAR Months 4 Days 4	IF UNDER 24 HRS. Hours 4 Min. 4
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Cambridge Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Stanley				14. MOTHER'S MAIDEN NAME Bertha Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Bertha Stanley, Cambridge, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Virus pneumonitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 492X (c) 492X							INTERVAL BETWEEN ONSET AND DEATH 2 days.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Epilepsy							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. 19 Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John Mace Jr.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) John Mace Jr.				DATE SIGNED 10/26/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/11/56		22c. NAME OF CEMETERY OR CREMATORY Salem Cemetery		22d. LOCATION (City, town, or county) (State) Salem, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Herbert St. Clair				ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR 10/26/56	
				24b. REGISTRAR'S SIGNATURE John Mace Jr.			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM-3. Pages 1 and 2 with this certificate, and the funeral permit, are to be retained by the funeral director. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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OCT 29 1956

may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completed, may file it with the registrar. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 could be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10265

CERTIFICATE OF DEATH

10264

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge				c. LENGTH OF STAY IN 1b 25 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vienna - Rural				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge - Maryland Hospital			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				d. STREET ADDRESS R.F.D. #1			
3. NAME OF DECEASED (Type or print) First Robert Middle Henry Last Stanley				4. DATE OF DEATH Month October Day 4 Year 1956			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 23, 1895	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months 60 Days 60 Hours 60 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Dorchester Co., Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Richard Stanley				14. MOTHER'S MAIDEN NAME Mary Wilson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 220-34-7591		17. INFORMANT Lena Stanley, Vienna, Maryland, R.F.D.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma pancreas with metastasis 157X DUE TO Infarct of right lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 25 days (c) 25 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 9/19 , 19 56 , to 10/4 , 19 56 , that I last saw the deceased alive on 10/4 , 19 56 , and that death occurred at 7:58 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cambridge Md DATE SIGNED 10/4/56 ACTUAL SIGNATURE W. H. Hanks M.D. PHYSICIAN'S NAME (Type) W. H. HANKS MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 7, 1956		22c. NAME OF CEMETERY OR CREMATORY Fork Neck Cemetery		22d. LOCATION (City, town, or county) (State) Vienna, Maryland, R.F.D.	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland				24a. REC'D BY REGISTRAR DATE 10/6/56		24b. REGISTRAR'S SIGNATURE J. J. Frampton	

MASSACHUSETTS DEPARTMENT OF HEALTH—BOSTON
 CERTIFICATE OF DEATH

1. Name of Deceased: *John F. Kennedy*
 2. Sex: *Male*
 3. Age: *35*
 4. Date of Birth: *May 29, 1917*
 5. Place of Birth: *Brookline, Mass.*
 6. Date of Death: *September 9, 1963*
 7. Time of Death: *9:58 AM*
 8. Cause of Death: *Assault by rifle fire*
 9. Place of Death: *John F. Kennedy Library, Boston, Mass.*
 10. Physician: *Dr. John B. Connally*
 11. Hospital: *John F. Kennedy Library*
 12. Burial Place: *St. Ignace Cemetery, Boston, Mass.*
 13. Burial Date: *September 12, 1963*
 14. Signature of Physician: *John B. Connally*
 15. Signature of Registrar: *John F. Kennedy*

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 OCT 11 1966
 BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10265

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cambridge-Maryland Hospital</u>				d. STREET ADDRESS <u>1 Church Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Guy</u> Middle <u>MMN</u> Last <u>Steele</u>				4. DATE OF DEATH Month <u>October</u> Day <u>12</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-23-1861</u>		9. AGE (In years last birthday) <u>95</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician - retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General practice</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas B. Steele</u>				14. MOTHER'S MAIDEN NAME <u>Isabella E. Henry</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <input checked="" type="checkbox"/> (If yes, give war or dates of service) <u>circa 1888</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Cambridge-Maryland Hospital Records</u> Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cardiac and renal failure</u> (c) <u>Shock due to inter-trochanteric fracture of left femur.</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arterio sclerosis, generalized and cerebral</u>							INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> <u>6 weeks</u> <u>48 days</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Deceased fell in bedroom and fractured left hip.</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Deceased fell in bedroom and fractured left hip.</u>					
20c. TIME OF INJURY Month, Day, Year <u>August 25-56</u> Hour a. m. <u>11:00</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Cambridge Dorchester Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Eldridge H. Wolff, M.D.</u>		EXAMINER'S NAME (Type) <u>Eldridge H. Wolff, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>10-12-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/14/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CHRIST CHURCH</u>		22d. LOCATION (City, town, or county) (State) <u>CAMBRIDGE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte FUNERAL SERVICE</u>				24a. REC'D BY REGISTRAR <u>10/14/56</u>		24b. REGISTRAR'S SIGNATURE <u>John W. [Signature]</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. If a burial permit is required, file pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

OCT 19 1956

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10279

CERTIFICATE OF DEATH

Reg. Dist. No. 110

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vienna - Rural				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Indiantown Road				d. STREET ADDRESS Indiantown Road			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Clarence Styles				4. DATE OF DEATH Month Day Year October 16 1956			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 14, 1896	9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Dorchester Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Styles				14. MOTHER'S MAIDEN NAME Lillie Ann			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 217-14-8696		17. INFORMANT Address Grace B. Pinder, Vienna, Maryland, R.F.D.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 260.0 (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 15, 1956 , to October 16, 1956 , that I last saw the deceased alive on October 16, 1956 , and that death occurred at 7:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE J. Edwin Fassett				ADDRESS (Street, city or town, state) DATE SIGNED 227 Pine St-Cambridge, Md.-10-18-56			
PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 20, 1956		22c. NAME OF CEMETERY OR CREMATORY Saul Landing Cemetery		22d. LOCATION (City, town, or county) (State) Near Vienna, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland				24a. REC'D BY REGISTRAR DATE Oct 20-1956		24b. REGISTRAR'S SIGNATURE Charles Hastings	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, may be required by the hospital or attending physician.

TO REGISTAR: This certificate should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED CLARENCE		SEX Male	
DATE OF BIRTH 1911		AGE 35	
PLACE OF BIRTH Maryland		CITY OF BIRTH Baltimore	
OCCUPATION Carpenter		EDUCATION High School	
MARRIAGE Married		DATE OF MARRIAGE 1935	
NAME OF SPOUSE Mary		DATE OF DEATH 1956	
PLACE OF DEATH Home		CITY OF DEATH Baltimore	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
DATE OF DEATH 1956		PLACE OF DEATH Home	
CITY OF DEATH Baltimore		STATE OF DEATH Maryland	
COUNTY OF DEATH Baltimore		ZIP CODE 21201	
SIGNATURE OF DECEASED Clarence		SIGNATURE OF WITNESS Mary	
DATE OF SIGNATURE 1956		DATE OF SIGNATURE 1956	
PLACE OF SIGNATURE Home		PLACE OF SIGNATURE Home	
CITY OF SIGNATURE Baltimore		CITY OF SIGNATURE Baltimore	
STATE OF SIGNATURE Maryland		STATE OF SIGNATURE Maryland	
COUNTY OF SIGNATURE Baltimore		COUNTY OF SIGNATURE Baltimore	
ZIP CODE 21201		ZIP CODE 21201	
DATE OF DEATH 1956		DATE OF DEATH 1956	
PLACE OF DEATH Home		PLACE OF DEATH Home	
CITY OF DEATH Baltimore		CITY OF DEATH Baltimore	
STATE OF DEATH Maryland		STATE OF DEATH Maryland	
COUNTY OF DEATH Baltimore		COUNTY OF DEATH Baltimore	
ZIP CODE 21201		ZIP CODE 21201	

BUREAU V. 8

OCT 23 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, number 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Numbers 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 10267

10280

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elliott			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital				d. STREET ADDRESS --			
3. NAME OF DECEASED (Type or print) First Alexander Middle Frank Last Thomas				4. DATE OF DEATH Month October Day 29 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 16, 1876	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Thomas		14. MOTHER'S MAIDEN NAME Nellie Hurley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. --		17. INFORMANT RECORDS: Eastern Shore State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis with heart disease years DUE TO Chronic Brain Syndrome associated with cerebral (c) Arteriosclerosis, with psychotic reaction years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 6 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 10-11 , 19 56 , to 10-29 , 19 56 , that I last saw the deceased alive on 10-29 , 19 56 , and that death occurred at 8:30 AM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE Simon Virkutis M.D.							
PHYSICIAN'S NAME (Type) Simon Virkutis				Eastern Shore State Hospital, Cambridge, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		10/31/56		Elliott		Elliott, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Keith S. Hillyoughy, East New Market Md				24a. REC'D BY REGISTRAR DATE 10/21/56		24b. REGISTRAR'S SIGNATURE John Macpherson	

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10281
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10268

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>			
c. LENGTH OF STAY IN 1b <u>2yr. 4 mos. 28 days</u>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore State Hospital</u>				d. STREET ADDRESS <u>400 Peach Blossom Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Warner</u> Middle <u>-</u> Last <u>Travers</u>			4. DATE OF DEATH Month <u>October</u> Day <u>24</u> Year <u>1956</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 10, 1870</u>		9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Benjamin Travers</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u> (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>RECORDS: Eastern Shore State Hospital</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis with heart disease</u> sev. years DUE TO (c) <u>Chronic Brain Syndrome associated with Cerebral Arteriosclerosis</u> sev. years							INTERVAL BETWEEN ONSET AND DEATH <u>one week</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5-26-54</u> , 19 <u>54</u> , to <u>10-24</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10-24</u> , 19 <u>56</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Simon Virkutis</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Dr. Simon Virkutis</u>				<u>Eastern Shore State Hosp., Cambridge, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 27, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Lawn</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service</u> ADDRESS <u>Cambridge</u>				24a. REC'D BY REGISTRAR <u>10/26/56</u> DATE		24b. REGISTRAR'S SIGNATURE <u>John Mase Jr.</u>	

BUREAU V. S.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, or other person authorized by law, should be detached for use as the burial-transit permit. Then please remove carbon papers. The registrars should be detached for use as the burial-transit permit, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10267

CERTIFICATE OF DEATH

10269

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge Md.</u>				c. LENGTH OF STAY IN 1b <u>Seven Months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u># 6 Light St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Della Meekins Wallace</u>				4. DATE OF DEATH Month Day Year <u>Oct. 25, 19 56.</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 7, 1872</u>	9. AGE (In years last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Church Creek Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Henry Meekins</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Gore</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Earl Wallace</u>		Address <u>#6 Light St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis, generalized</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>20 hours</u> <u>5 years+</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Old homiplegia with loss of speech</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____				
20c. TIME OF INJURY Hour a. p. m. _____ Month, Day, Year _____ _____ 19 _____			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>5-15</u> , 19 <u>56</u> , to <u>10-25</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10-24</u> , 19 <u>56</u> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Eldridge H. Wolff</u> M.D. <u>15 Locust Street, Cambridge, Maryland</u> <u>10-26-56</u> PHYSICIAN'S NAME (Type) <u>Eldridge H. Wolff, M.D.</u> <u>11/1/56 John Mace Jr.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 28, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Old Trinity Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Church Creek Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service</u>				ADDRESS <u>Cambridge Md.</u>		24a. REC'D BY REGISTRAR DATE <u>11/1/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>John Mace Jr.</u>			

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10268

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 5 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Hospital		d. STREET ADDRESS Oxford	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Sarah Jane Waters		4. DATE OF DEATH Month 10 Day 29 Year 1956	
5. SEX Female	6. COLOR OR RACE Col	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/1/1858
9. AGE (In years last birthday) 98 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Williams Adams		14. MOTHER'S MAIDEN NAME Louisa Goldsbrough	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 4-4-4		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Robert Banks		Address Oxford, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 16 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/14/56 , 19 56 , to 10/29 , 19 56 , that I last saw the deceased alive on 10/29 , 19 56 , and that death occurred at 6:50 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Edwin Fasset		M.D.	
PHYSICIAN'S NAME (Type) Edwin Fasset		Cambridge Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/1/56	22c. NAME OF CEMETERY OR CREMATORY Oxford Cemetery	22d. LOCATION (City, town, or county) (State) Oxford Maryland
23. FUNERAL DIRECTOR'S SIGNATURE James B. Portwell, Eastern, Md		24a. REC'D BY REGISTRAR DATE 9 1956	
ADDRESS		24b. REGISTRAR'S SIGNATURE John Mace, Jr.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		45		M		W		1956		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF BURIAL		PLACE OF BURIAL	
1234 E. BALTIMORE ST.		LABORER		HEART DISEASE		NATURAL		11/10/56		CATHOLIC CHURCH	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		MARRIAGE		SINGLE		MARRIED	
1911		BALTIMORE, MD.		HIGH SCHOOL		MARRIED		MARRIED		MARRIED	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DATE OF BURIAL		PLACE OF BURIAL	
11/10/56		BALTIMORE, MD.		HEART DISEASE		NATURAL		11/10/56		CATHOLIC CHURCH	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		MARRIAGE		SINGLE		MARRIED	
1911		BALTIMORE, MD.		HIGH SCHOOL		MARRIED		MARRIED		MARRIED	

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NOV 9 1956
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10271

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester 10269 MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN 1b 42 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge-Maryland Hospital				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, R.D. 1 d. STREET ADDRESS Rural e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Malkus Last Weber				4. DATE OF DEATH Month October Day 22 Year 1956									
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 7, 1874		9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 82 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Md.				11. BIRTHPLACE (State or foreign country) U.S.					
13. FATHER'S NAME Philip C. Malkus Sr.				14. MOTHER'S MAIDEN NAME Kunigunda Foeller									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Frederick C. Malkus, Jr., Cambridge, Md.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) General carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (b) Adeno carcinoma breast (c), stating the underlying cause lost. 90400 DUE TO										INTERVAL BETWEEN ONSET AND DEATH 6 Mo. 10 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pathological fracture middle third l. femur													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Slipped and fell in her home.									
20c. TIME OF INJURY Month, Day, Year 1/12/ 19 56 Hour 3 PM o. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Cambridge R.D. Dor. Md.		(County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>													
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Mace Jr.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 10/23/56					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Oct. 24, 1956		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery				22d. LOCATION (City, town, or county) Baltimore, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Samuel R. Thomas, Cambridge, Md.						24a. REC'D BY REGISTRAR DATE OCT 23 1956		24b. REGISTRAR'S SIGNATURE John Mace Jr.					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. If a burial, cremation, or removal, file pages 1 and 2 with the registrar prior to the burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 8

OCT 23 1956

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. If the death is a result of a violent or unusual cause, the funeral director must obtain a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10282

Reg. Dist. No.

10272

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Enroute to Hospital</u>		c. LENGTH OF STAY IN 1b <u>0</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wingate Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Enroute To Hospital</u>				d. STREET ADDRESS <u>Wingate Md.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Curtiss Carroll Willey</u>				4. DATE OF DEATH Month Day Year <u>Oct. 31, 1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 15, 1898</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Edon Summerset Co.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Benjamin Willey</u>				14. MOTHER'S MAIDEN NAME <u>Rosa Washburn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Not Known</u>		17. INFORMANT Address <u>Mrs. Clara Dean Wingate Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary Occlusion</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John Mace Jr.</u> EXAMINER'S NAME (Type)				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED <u>Nov. 1, 1956</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 3, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service</u>				ADDRESS <u>Cambridge Md.</u>		24a. REC'D BY REGISTRAR <u>John Mace Jr.</u>	
				24b. REGISTRAR'S SIGNATURE			

STATE DEPARTMENT OF HEALTH - BUREAU OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

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